

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/25/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00104986 completed on March 14, 2012.</p> <p>This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00102677 conducted on March 14, 2012.</p> <p>Complaint #IN00104986: Corrected.</p> <p>Dates of Survey: April 24 and 25, 2012</p> <p>Facility number: 001100 Provider number: 15G586 AIM number: 100240050</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>Bona Vista Programs, Inc. was found to be in compliance with 42 CFR, Part 483, Subpart I, and 460 IAC 9 in regard to the post certification revisit to the investigation of complaint #IN00104986. Quality Review completed 5/1/12 by Ruth Shackelford, Medical Surveyor III.</p>			{W 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.